



Plan Management

Interim Policies & Procedures – Key Considerations

Presentation to: Exchange Board of Trustees
September 11, 2012

A service of Maryland Health Benefit Exchange

What is Plan Management?

Plan Management encompasses a broad range of functions that are required for certification of a state-based Exchange.

Plan Set Up

- Insurer Contracting
- Certification

Plan Compliance

- Recertification
- Maintain Operational Data
- Rate Increase Justifications
- Plan Decertification

Plan Presentment

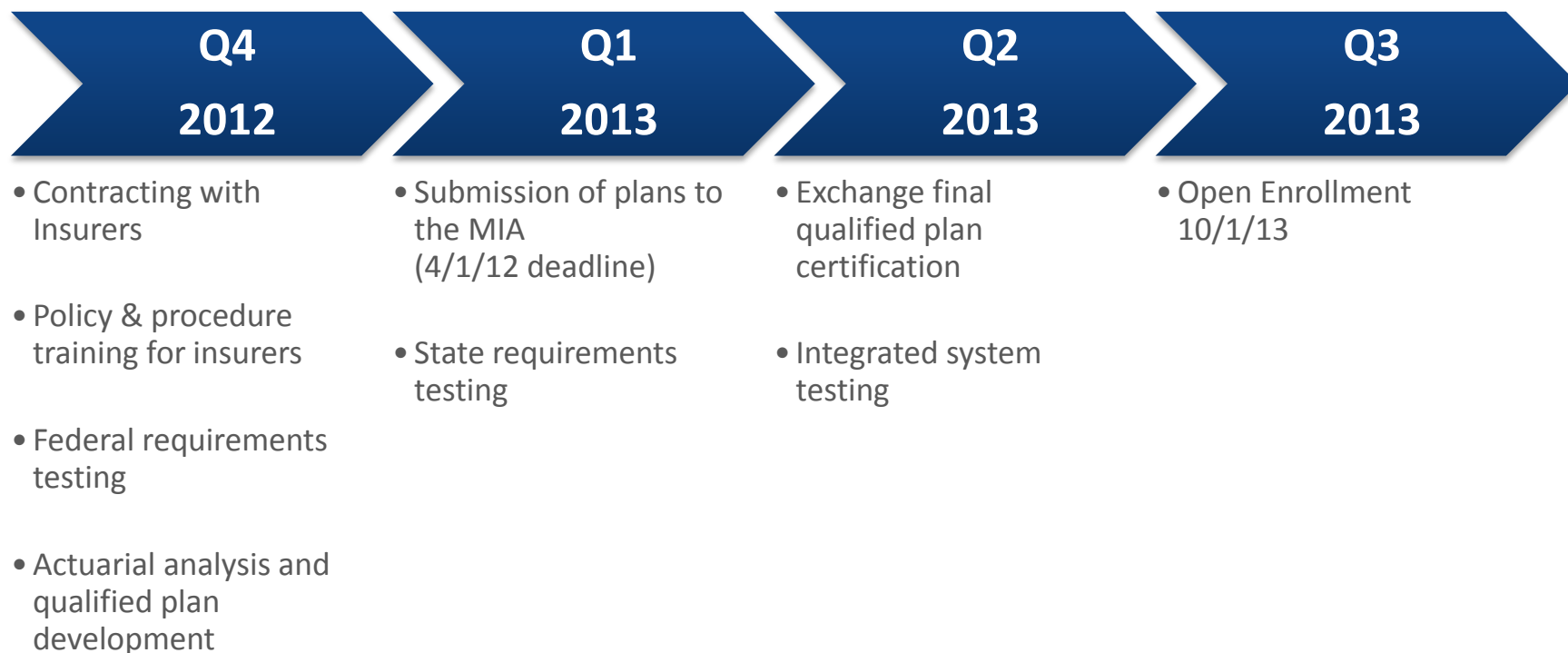
- Plan Searches
- Plan Comparisons
- Plan Availability Changes

- ✕ The Maryland Health Benefit Exchange will use the following guiding principles to establish its approach to Plan Management:
- **Promote affordability** for the consumer and small employer
 - **Ensure access to quality care** for consumers presenting with a range of health statuses and conditions
 - **Facilitate informed choice of health plans and providers** by consumers and small employers
 - **Reduce health disparities** and foster health equity

Plan Management Interim Procedures

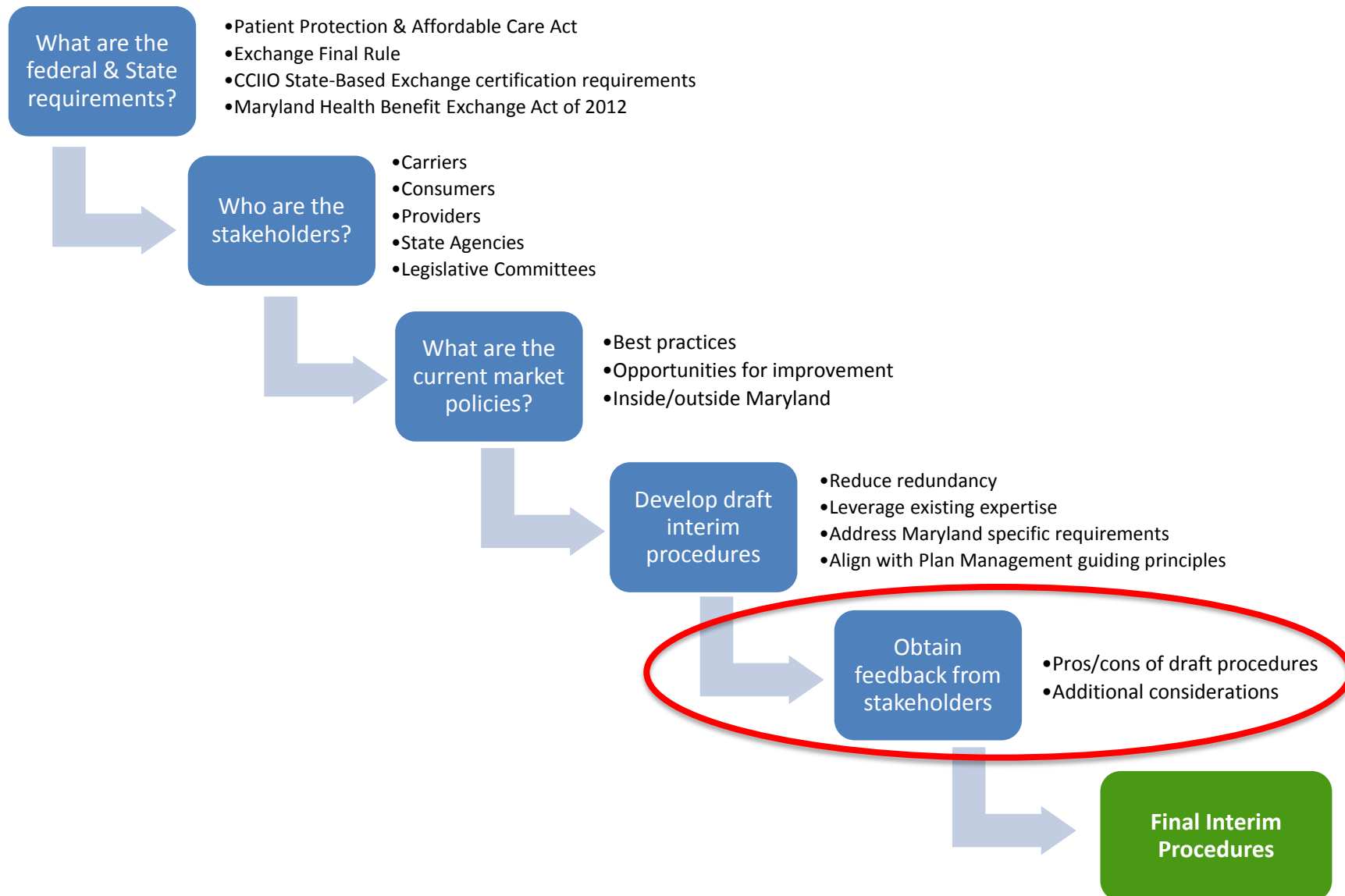


The Maryland Health Benefit Exchange Act of 2012 allows for the adoption of ***interim procedures*** so the Exchange can meet federal requirements and carriers offering qualified plans on the Maryland Health Connection in 2014 will have sufficient time to design and develop qualified plans and file rates.



- ✧ The interim procedures will cover the essential steps needed for insurers to offer health plans on the Maryland Health Connection.
- ✧ Interim procedures will guide the initial year of qualified plan development and oversight.

Interim Procedures - Development Pathway



- ✦ Draft interim procedures have been created for:
 - Plan Certification
 - Leverage MIA and MHCC existing commercial market processes
 - Use federal standards where possible
 - Plan for new market entrants
 - Use a Maryland RELICC Assessment to identify disparities
 - Plan Recertification
 - Annual reviews and biennial recertification
 - Plan Decertification
 - Plan compliance and quality standards
 - Plan Choice Design
 - Carrier submission limits
 - Standardized Plans

- ✧ Feedback has been received from key stakeholders
 - Plan Management Advisory Committee Comments
 - Public Comments

- ✧ Legislative committees' feedback is scheduled to be received by September 17th
 - Joint Committee on Administrative, Executive and Legislative Review
 - Senate Finance Committee
 - House Health and Government Operations Committee

- ✧ Stand-alone dental and vision draft interim procedures will be developed separately
 - How to offer?
 - Pricing Display

- ✧ Each decision area has been set up with quadrants to summarize:
 - Federal and/or State Requirement(s)
 - Options
 - Key Considerations
 - Recommendations

- ✧ Recommendations will be presented at the September 25th Board meeting

Plan Certification



Plan Certification Workflow



Step 1

Insurer Application/ Attestation

Maryland Market Rules

Service Area Requirements

Marketing Standards

Transparency Standards

Quality Data Requirements

Tracking of RELICC Data

Reporting Requirements

Step 2

MIA Review & Approval

SERFF or Insurer Upload

Licensure

Solvency

Benefits, Rates & Forms

Essential Health Benefits

Limitations on Cost Sharing

Actuarial Value/Metal
Levels

Discriminatory Benefit
Design

Step 3

Exchange Final Certification

HIX

Accreditation

Network Adequacy Data

Essential Community
Provider Data

Transparency Data

Step 4

MHCC Quality & RELICC Data

Annual Custom File

HMO/PPO HEDIS Scores

HMO/PPO CAHPS Scores

Dental Plan CAHPS Scores

Vision Plan CAHPS Scores

RELICC Data
(Internal use only)

Licensure & Solvency

Federal and/or State Requirement

An insurer must be licensed and in good standing. Insurers are required to meet state financial and solvency standards.

Options

1. Develop Exchange-specific licensure and solvency requirements.
2. Defer to the MIA for licensure and solvency.

Key Considerations

Current Market Practice

The Maryland Insurance Administration (MIA) currently grants certificates of authority to insurers. The MIA has oversight of company solvency to make sure claims can be paid.

Administrative Readiness

Separate licensure and solvency requirements would create a burden on insurers.

Timeline

The short implementation timeline may limit the ability of insurers to meet new licensure and solvency requirements.

Recommendation

TBD

Service Area

<p><u>Federal and/or State Requirements</u></p> <p>Insurers must have service areas that cover a minimum geographical area that is at least a county. Carriers must establish service areas in a non-discriminatory manner without regard to race, ethnicity, language or health status of the individuals in the service area.</p>	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. Allow insurers to self-define service area as long as at least a county is covered. 2. Require insurers to use the same service area as the commercial market or MCO market 3. Require all insurers to operate statewide.
<p><u>Key Considerations</u></p> <p>Current Market Practice Medicaid defines service areas for MCOs supporting the Medicaid population. HMO and PPO insurers self-define service areas.</p> <p>Continuity of Care The Exchange needs to consider how insurer service areas support churn as consumers move from Medicaid, to employer sponsored coverage or to plans offered on the Maryland Health Connection.</p> <p>Business Model of Insurers New market entrants such as Consumer Operated and Oriented Plans (CO-OPs) may not be able to support statewide service areas. Some existing insurers do not operate statewide and could not meet a requirement to do so.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Benefit Design Standards

<p style="text-align: center;"><u>Federal and/or State Requirements</u></p> <p>Insurers must not employ benefit designs that discourage enrollment by higher need consumers. Plans offered by insurers must meet the requirements for “qualified” plans (e.g., Essential Health Benefits, actuarial value, limitations on cost-sharing, non-discriminatory benefit design).</p>	<p style="text-align: center;"><u>Options</u></p> <ol style="list-style-type: none"> 1. Defer to the MIA for benefit design review. The MIA will ensure all federal and state requirements are included within plans. 2. Develop a new, separate Exchange-specific benefit design review process to meet federal requirements.
<p style="text-align: center;"><u>Key Considerations</u></p> <p>Current Market Practice By statute, the MIA has authority to review benefit plans to ensure compliance with Maryland laws, the inclusion of mandated benefits and non-discrimination in product design.</p> <p>Resources Significant resources and expertise are needed to review benefit plans and ensure compliance with the law.</p> <p>New Requirements The Affordable Care Act and Mental Health Parity & Addiction Equity Act (MHPAEA) include new requirements that are not included in today’s benefit design review process for small group and individual market.</p>	<p style="text-align: center;"><u>Recommendation</u></p> <p>TBD</p>

Rate Changes

<p><u>Federal and/or State Requirements</u></p> <p>Insurers must provide justification for any rate increase prior to implementing increases. Exchanges must consider that justification in determining whether to certify or recertify a qualified plan.</p>	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. Defer to the MIA for the review of rate changes. 2. Develop a new, separate Exchange-specific review process for rate changes.
<p><u>Key Considerations</u></p> <p>Current Market Practice</p> <p>By statute, the MIA is responsible for performing a review for all rate changes. Justification forms will be required and will be posted on the MIA website for consumer comment along with a consumer friendly summary.</p>	<p><u>Recommendation</u></p> <p>TBD</p>

Marketing Standards

<p><u>Federal and/or State Requirements</u></p> <p>Insurers must comply with all applicable State laws governing marketing of insurance plans and cannot discourage enrollment of individuals with significant health needs. Communications must be simple and understandable terms, use Plain Language and language that is accessible to people with Limited English Proficiency.</p>	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. File and Approve Policy - Require all marketing materials to be approved by the Exchange before use. 2. File and Use Policy - Require all marketing materials to be filed with the Exchange before use but no approval is needed. 3. Standardized Text Requirement - Require standardized language developed by MIA and Exchange for all marketing materials used in the state.
<p><u>Key Considerations</u></p> <p>Current Market Practice</p> <p>In the commercial market, Medicare Supplemental Plans and Long Term Care plans are the only plans that require prior approval of marketing materials. All other materials are dealt with on a complaint and audit basis. Medicaid MCOs must file and gain approval before use.</p> <p>Consumer Protection</p> <p>The Exchange and insurers will be marketing to consumers so confusion may arise unless there are mechanisms to ensure appropriate communication to consumers.</p> <p>Resources</p> <p>In the initial year, significant marketing will be needed to encourage enrollment. This will lead to a large volume of materials to review. If approval is required, Exchange staffing levels must be appropriate to ensure a timely turnaround.</p>	<p><u>Recommendation</u></p> <p>TBD</p>

Network Adequacy

Federal and/or State Requirements

Insurers are required to maintain provider networks that are sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delays. An insurer must make its provider directory, indicating providers not accepting new patients, available to current and prospective enrollees.

The Maryland Insurance Article requires that insurers update online directory data at least every 15 days.

Options

1. Develop standardized network adequacy requirements for all insurers participating with the Exchange.
2. Allow insurers to “self-define” network adequacy requirements and perform audits to ensure requirements are met.

Key Considerations

Current Market Practice

Medicaid provides prescriptive requirements for MCO network adequacy. For PPO and HMO plans, network adequacy is defined by the insurers.

Access to Care

Little data is available on the population’s network needs. It is expected that high enrollment volume and pent up demand will require robust networks to be available.

Adverse Selection

Creating a separate (more rigorous) network standard could result in adverse selection for the Maryland Health Connection.

Timeline

The short implementation timeline may limit the ability of insurers to expand networks in time for open enrollment in 2013.

Recommendation

TBD

Essential Community Providers

<p><u>Federal and/or State Requirements</u></p> <p>Insurers must include a sufficient number and geographic distribution of Essential Community Providers (ECPs) that serve low-income and medically underserved individuals. ECPs are defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act.</p> <p><i>Alternate standard:</i> Insurers that provide a majority of covered services through employed physicians can satisfy the standard by using employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities.</p>	<p><u>Options</u></p> <p>Definition of ECPs</p> <ol style="list-style-type: none"> 1. Use the federal definition of ECPs only. 2. Expand the definition of ECPs to include more provider types. <p>Sufficiency Standard</p> <ol style="list-style-type: none"> 1. Establish standardized requirements including a specific number and geographic distribution of ECPs. 2. Allow insurers to “self-define” standards for inclusion of ECPs.
<p><u>Key Considerations</u></p> <p>Access to Care & Transparency</p> <p>ECPs will serve as a needed safety net for traditional commercial networks. Consumers will need to know who these providers are to assist in their decision making process.</p> <p>Continuity of Care</p> <p>Many uninsured use the federally designated ECPs and other provider types as primary care providers. Expanding the definition of providers will allow for continued services when people churn from Medicaid to the Maryland Health Connection.</p> <p>Administrative Readiness</p> <p>Some ECPs may not be prepared for credentialing, eligibility verification, claims billing required to join commercial networks in time for open enrollment in 2013.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Accreditation

<p><u>Federal and/or State Requirements</u></p> <p>Insurers are required to obtain accreditation within a timeframe specified by the Exchange. HHS has recognized URAC & NCQA as authorized accreditation entities.</p>	<p><u>Options</u></p> <p>Grace Period</p> <ol style="list-style-type: none"> 1. Allow a grace-period for non-accredited insurers to initially participate with no accreditation. 2. Do not allow a grace period.
<p><u>Key Considerations</u></p> <p>Current Market Practice Insurers are not required to obtain accreditation in the commercial or Medicaid markets however some do have accreditation already.</p> <p>URAC vs. NCQA Accreditation URAC includes a review of MHPAEA as part of accreditation. NCQA accreditation is more prevalent for Maryland insurers.</p> <p>New Commercial Market Entrants New market entrants including Consumer Operated and Oriented Plans (CO-OP) and MCOs that establish commercial lines of business may not have commercial plan accreditation.</p> <p>Stand-Alone Dental & Vision Plans No accreditation entities exist for stand-alone dental and vision plans.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Transparency Data

<p><u>Federal and/or State Requirements</u></p> <p>Insurers must report to the HHS, Exchanges, state departments of insurance, and the public information on key policies, practices and data on cost sharing including:</p> <ul style="list-style-type: none"> • Claims payment policies and practices • Financial disclosures • Information on enrollee rights • Upon request of an individual, information on cost-sharing with respect to a specific item/service • Data on enrollment/disenrollment • Data on number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage 	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. Insurers will only be required to provide the transparency data required by federal law. 2. Insurers will be required to provide expanded transparency data reporting specific to Maryland's needs.
<p><u>Key Considerations</u></p> <p>Affordability/Quality Transparency data will provide a better basis for consumers to make purchase decisions. More information will also foster competition which could drive down costs and improve quality.</p> <p>Timeline Insurers have a short timeline to get systems ready for new data reporting requirements.</p> <p>Federal Guidance Additional guidance on reporting requirements is expected from the federal government. The Exchange policy should not conflict with federal requirements.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

RELICC Data Tracking

Federal and/or State Requirements

The Maryland Health Benefit Exchange Bill of 2011 requires annual reporting to the General Assembly including data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, or other attributes of special populations.

Options

1. Develop an Exchange-specific process to collect disparity data from insurers.
2. Require insurers to participate in the MHCC Maryland RELICC Assessment process.

Key Considerations

Current Market Practice

The Maryland Health Improvement and Disparities Reduction Act of 2012 expanded the authority of MHCC to establish and implement a system to evaluate and compare the quality and performance of care provided by commercial health benefit plans.

The Maryland Health Care Commission (MHCC) has announced a process for health insurers to track and collect race, ethnicity, language, interpreter need and cultural competence (RELICC) data for benefit year 2012.

Maryland Disparities

DHMH Office of Minority Health and Health Disparities has collected data to indicate a wide difference in health outcomes between Whites and other minorities

Recommendations

TBD

Quality

<p><u>Federal and/or State Requirements</u></p> <p>The Exchange must evaluate insurers' quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.</p>	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. Develop an Exchange-specific quality performance system for insurers. 2. Require insurers to participate in MHCC's system for quality. MHCC will incorporate stand-alone dental and vision plans into the quality process.
<p><u>Key Considerations</u></p> <p>Current Market Practice</p> <p>The Maryland Health Care Commission (MHCC) currently has a plan quality and performance evaluation system for medical insurers with a premium volume in Maryland that exceeds \$1 Million.</p> <p>The system includes the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) and the AHRQ Consumer Assessment of Health Providers and Systems (CAHPS).</p> <p>Stand-alone Dental & Vision Plans</p> <p>MHCC does not currently include stand-alone dental and vision plans in the plan quality and performance processes. HEDIS is not designed for these plans. The standard CAHPS enrollee survey is designed for medical plans.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Plan Recertification



<p><u>Federal and/or State Requirements</u></p> <p>The Exchange must complete the recertification process to ensure that carriers and consumers are fully informed of the qualified plan choices well in advance of open enrollment.</p>	<p><u>Options</u></p> <p>Define an Exchange specific plan recertification process.</p>
<p><u>Key Considerations</u></p> <p>Due Process Failure to recertify a plan could significantly limit an insurers ability to be competitive in the State. Because of this, if a plan fails recertification due process rights should be available for insurers.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Plan Decertification



<p><u>Federal and/or State Requirements</u></p> <p>The Exchange has the authority to decertify a plan that is no longer meeting the required certification standards. HHS has further clarified that exchanges will have the ability to impose intermediate sanctions for noncompliance that fall short of full decertification.</p>	<p><u>Options</u></p> <p>Define an Exchange specific decertification plan.</p>
<p><u>Key Considerations</u></p> <p>Due Process Decertification could significantly limit an insurers ability to be competitive in the State. Because of this the decertification strategy should include due process rights for insurers.</p> <p>Consumer Impact Decertification of a plan requires that a special enrollment period be offered to allow consumers enrolled in the decertified plan to select another alternative plan.</p> <p>Timing Decertification of plans should coincide with open enrollment wherever possible to minimize disruption/impact to enrollees.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Plan Choice



Submission Limits

<p>N/A</p> <p><u>Federal and/or State Requirements</u></p>	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. Establish a maximum number of benefit designs per metal level that insurers can offer. 2. Allow unlimited number of plans to be offered by insurers as long as they meet certification and recertification requirements.
<p><u>Key Considerations</u></p> <p>Consumer Impacts With no limitations on the number of plans that carriers can offer, the volume of plans on the Maryland Health Connection is expected to grow very quickly. Offering too many choices to consumers could result in confusion and frustration.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Standardized Plans

<p><u>Federal and/or State Requirements</u></p> <p>N/A</p>	<p><u>Options</u></p> <ol style="list-style-type: none"> 1. The Exchange will require insurers to offer a standardized plan at each metal level. 2. The Exchange will not require any plan standardization.
<p><u>Key Considerations</u></p> <p>Plan Variation All health benefit plans offered must provide coverage for all Essential Health Benefits and meet the actuarial value requirements for the Platinum, Gold, Silver, or Bronze metal tiers. While these requirements ensure minimum coverage and a level of standardization, they allow for a wide range of potential variation in plan designs.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

Consumer Steering

<p><u>Federal and/or State Requirements</u></p> <p>Some states are taking steps to ensure Producer compensation programs do not result in steerage of consumers away from the Exchange. Examples of activities being implemented or explored include:</p> <p>CA – Proposal has been made to require producer compensation parity inside and outside of the Exchange.</p> <p>OR – Transparency requirement by DOI includes public display of commission information.</p>	<p><u>Options</u></p> <p>TBD</p>
<p><u>Key Considerations</u></p> <p>Current Market Practice Producers are compensated for plans sold in the commercial market. Compensation could vary by insurer, by plan and by Producer.</p> <p>Adverse Impact Lower Producer compensation for Maryland Health Connection plans could be a disincentive to place business in those plans.</p> <p>State Role Historically the State has not been involved in Producer compensation.</p>	<p><u>Recommendations</u></p> <p>TBD</p>

September 25th Board Meeting

- ✧ Exchange staff will present recommendations for each policy area
- ✧ The Exchange Board will be asked to adopt the recommendations as the interim procedures

October - Preparation for Insurers

✕ Plan Management Manual

✕ Policy Training Sessions

- Joint sessions with Exchange and MIA staff to review final requirements for plan certification
 - October 18th
 - October 24th

Thank you!

For questions on the information
contained in this presentation, please contact:

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